Mentoring HIV Clinicians in Eastern Cape Province, RSA

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Background

- Technical assistance provided to Regional Training Center (RTC) and Eastern Cape Department of Health (ECDoH) beginning before the national ARV roll out and continuing through the initial implementation period
- 2 components of assistance
  - Demonstration model of care involving 2 hospitals and 9 feeder clinics in Mthatha region
  - Responsibility for facilitating clinical training throughout the Eastern Cape

Background

- Initial support included
  - Facilitation of planning regarding requirements for effective systems of care
  - Didactic and small group trainings for physicians, nurses, and pharmacists at key care sites throughout the Eastern Cape
    - 50% didactic
    - 50% small group strategizing about local implementation issues
  - Focus on diagnosis, staging, monitoring, prophylaxis, and management of OIs

Phase 2: Early ARV Rollout

- Intensive technical support to central HIV clinic at Mthatha General Hospital by UCSD Nurse Practitioner (Mary McCarthy)
  - No clinic appointment system
  - Poor infection control practices
  - Poor coordination between inpatient and outpatient care (including TB, VCT, PMTCT, primary care, casualty settings)
  - Inadequate physician leadership and presence in clinic leaving nurses on their own most of the time

Phase 2: Early ARV Roll Out

- Case-based small group training and precepting at key care sites participating in the first phase of ARV roll out.
  - Port Elizabeth, Grahamstown, Queenstown, East London, Mthatha, Flagstaff, Rietvlei, Lusikisiki, Bizana
- Pre-training logistics arranged by RTC clinical director
  - Each site asked to prepare cases to be discussed, preferably with patients present

Phase 2: Key Observations

- Wide variability in site preparation for clinical precepting
  - "Who will see the patients in casualty if I come to this?"
  - Lack of regular meetings to review and learn from cases
    - "It would be like the blind leading the blind"
  - A few sites had their act together with well prepared outpatient and inpatient cases for review

Phase 2: Key Observations

- Clinical issues
  - Many patients getting sick within weeks after starting ARVs and ending up in district hospitals with medical staff very poorly trained to recognize and effectively manage IRIS reactions
  - Essentially no pharmacovigilance
    - Anecdotal reports of 3 highly probable cases of fulminant lactic acidosis
    - Patients started on d4T containing regimens with already significant peripheral neuropathy
    - Inadequate knowledge of adverse drug interactions
  - Limited ability to “think outside of the box” when patients with contraindications to algorithmic treatment present for care

Phase 2: Key Observations

- Clinical issues
  - Identified 5 local physicians with sufficient experience to serve as mentors and consultants regionally (3 adult, 2 pediatric)
    - Mechanisms not in place to support them
    - No infrastructure to promote mentoring and consultation services

Phase 2: Challenges

- Organizational unit charged with over site of provincial training (RTC) has multiple competing demands, high staff turner over, and multiple unfilled posts, and attend seemingly endless meetings
- Priority has been given to didactic level 1 trainings
- Very limited attention to date to advanced clinical training
  - Limited “in house” expertise
  - Too busy to accommodate external mentors

Training Issues

- Precepting and mentoring in clinic and bedside is remarkably effective way to identify sentinel cases from which PowerPoint training modules can be developed and disseminated
- Examples
  - Recognizing and managing early onset IRIS
  - Drug interactions (hormonal contraceptives and ARVs
  - Management of increased ICP in cryptococcal meningitis
  - Treatment experienced patient
  - Patient with advanced KS and TB
  - Appropriate triage strategies based on severity of illness and resource capacity

Training Issues

- External mentors seem essential at current time due to inadequate core group of experienced clinical experts
- Goal is to intensively mentor local key clinicians who can serve as mentors and consultants

Training Issues

- Infrastructure to support mentoring is necessary first step to success
  - Who will be mentored?
  - Will they be given time to be mentored
  - Identification of sentinel cases
    - Common complications
    - Rare but serious complications
    - Multidimensional decision-making
    - Morbid outcomes

Training Issues

- Follow up after precepting
  - Who can the local mentors and trainees contact for advice?
  - What venues are convenient to use for communication?
  - Opening the channels of communication (mobile phone, email, etc)
    - Importance of personal relationships
  - Monitoring of quality indicators
    - Loss to follow up rates
    - Deaths and hospitalizations within 3 months of starting ARVs
    - SAEs (e.g. lactic acidosis)

Training Issues

- Importance of regular team meetings to learn from one another
  - Need to have ready access to external support to avoid “blind leading the blind” phenomenon
- Both inpatient and ambulatory precepting is needed
  - IRIS and OI management
  - Coordination of care strategies

Training Issues

- Inadequate attention to management of the seriously ill may have public health consequences
  - Patients may associate ARVs with rapid deterioration and death
  - e.g. comments of RSA Minister of Health

Perspective Issues

- False dichotomy between “Public Health Approach” and “Clinical Approach”
  - Common clinical problems poorly managed lead to poor outcomes at the population level
  - In the clinic, you treat one patient at a time and each one deserves the most that the provider and system of care can offer

Perspective Issues

- At recent case-based training session in Lusikisiki involving 25 physicians and 4 pharmacists, an MSF physician told the group
- “Don’t get the impression that most people have problems on ARVs. Most do well.”
- True in general, but it depends on stage of disease and co-morbidity at time of ARV initiation
- Currently, many presenting for ARVs are already symptomatic
- Because of poor follow up, the dead aren’t counted—the just fade away.